

# PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST FUND

## \*\*\* LIFE INSURANCE BENEFICIARY DESIGNATION FORM \*\*\*

PLEASE COMPLETE AND SIGN THIS FORM IN INK MAKE A COPY FOR YOUR RECORDS  
AND RETURN THE SIGNED ORIGINAL TO:

ADMINISTRATIVE SERVICES ONLY, INC P.O. BOX 9010, LYNBROOK NY 11563

### SECTION I MEMBER INFORMATION (be sure to sign/date and must have form witnessed below)

LAST NAME	FIRST NAME	MI	SOC SEC NO	DATE OF BIRTH
ADDRESS		APT NO	CITY	ST ZIP
HOME PHONE	CELL	EMAIL		

### SECTION II PRIMARY BENEFICIARY INFORMATION (See Reverse Side for Definition)

FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.
FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.
FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.
FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.

### SECTION III CONTINGENT BENEFICIARY INFORMATION (See Reverse Side for Definition)

FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.
FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.
FULL NAME	ADDRESS	APT NO	SOCIAL SECURITY NO	DATE OF BIRTH
	CITY	ST	ZIP	RELATIONSHIP TELEPHONE NO.

### SECTION IV AUTHORIZATION (THIS FORM MUST BE SIGNED AND WITNESSED)

**\*\*\* Form must be witnessed by a person *not* named as a primary beneficiary or contingent beneficiary \*\*\***

By my signature below, I revoke any Beneficiary Designations previously made, authorize payment to the beneficiary(ies) designated above, and agree, on behalf of myself and my heirs, that payment made to such beneficiaries shall be a complete discharge of any claim for such benefits and shall constitute a release of the Plan from any further obligation.

Member Signature:	Date:	Witness Signature:	Date:
Member Name (Print):		Witness Name (Print):	
		Address:	

## INSTRUCTIONS

These instructions will assist you in properly completing the **Primary and Contingent Beneficiary sections of the Beneficiary Designation Form**. Please be advised, any discrepancy between the information in these instructions and the Group Term Life Insurance Policy, the Group Term Life Insurance Policy shall govern.

It is **very important** that you take the time now to designate who will receive the Group Life Insurance proceeds in the event of your death. If you do not do so, the benefit order in which benefits are paid is as follows:

- Surviving spouse; if none,
- Surviving children in equal shares; if none,
- Surviving parents in equal shares; and if none,
- Surviving brothers and sisters in equal shares.

However, the Company has the option to make the payment to the administrators of your estate.

In order to designate a beneficiary to receive any benefits payable in the event of your death, **you must sign and date the Beneficiary Designation Form attached to this notice and return it to ADMINISTRATIVE SERVICES ONLY, INC P.O. BOX 9010, LYNBROOK NY 11563**

- \* The validity of your designation under the law is **YOUR** responsibility. Be precise and clear
- \* **Before making beneficiary designations, you may want to consult with a tax or legal advisor.**
- \* If you wish to name your estate, insert "Estate" in the blank space.
- \* You may change a Beneficiary Designation **at any time**.
- \* **Please Note:** You cannot name your employer as a beneficiary for Group Life Insurance proceeds under the Group Policy.
- \* If a beneficiary is living at the time of the employee's death but dies before receiving full benefits, the remaining proceeds will be paid to the beneficiary's estate.

**Primary Beneficiary(ies)** receive any death benefits payable subject to eligibility for coverage in the **PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST FUND** (hereinafter "Plan"). If designating more than one Primary Beneficiary, benefits will be paid in **equal shares** to the surviving Primary Beneficiary(ies).

**Contingent Beneficiary(ies)** receive any death benefits described above if they are alive at the time of your death **and if NO Primary Beneficiary is alive at the time of your death**. If you designate more than one Contingent Beneficiary, benefits will be paid in **equal shares** to the surviving Contingent Beneficiary(ies).

**Changing Beneficiary(ies)** You may change the designation(s) made herein at any time. Any such change shall be effective only if you make it in writing and it is actually received by the Trustees prior to your death. By submitting a new Beneficiary Designation Form, you revoke any Beneficiary Designations made prior to the date of the new designation. By completing the reverse side of this form, you authorize payment to the beneficiary(ies) whom you have designated and agree, on behalf of yourself and your heirs, that payment made to such beneficiaries shall be a complete discharge of any claim for such benefits and shall constitute a release of the Plan from any further obligation.

**IF THE BENEFICIARY(IES) IS (ARE) BEING CHANGED, THE NEW BENEFICIARY(IES)  
WILL REPLACE ALL PRIOR DESIGNATIONS AND  
WILL BE EFFECTIVE AS OF THE DATE OF THIS FORM.**

